

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-014752

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 1 Primary Registration District No. 3000 Registrar's No. 131

STATE FILE NUMBER

FILED APR 23 1963

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Rev. 4/59

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DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

| | | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Adair | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Sullivan | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kirksville | | Length of stay in 1b 11 days | c. CITY OR TOWN Green Castle Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Laughlin Hospital | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) Nostreet address Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First John Middle Samuel Last Abernathy | | 4. DATE OF DEATH Month April Day 2 Year 1963 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 11/9/1881 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer | | 10b. KIND OF BUSINESS OR INDUSTRY General farming | 9. AGE (last birthday) 81 IF UNDER 1 YEAR Months Days Hours Min. |
| 11. BIRTHPLACE (City and state or country) Stahl, Mo. | | 12. CITIZEN OF WHAT COUNTRY USA | |
| 13a. FATHER'S NAME Hugh Abernathy | | 13b. MOTHER'S MAIDEN NAME Celina Powell | |
| 14. NAME OF HUSBAND OR WIFE Mabel Irena Abernathy | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of) No | |
| 16. INFORMANT Mrs. Irena Abernathy, Green Castle, Mo. | | 17. ADDRESS Green Castle, Mo. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION DUE TO (b) GENERALIZED ARTERIOSCLEROSIS WITH DUE TO (c) SUB-ENDOCARDIAL ISCHEMIA Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | INTERVAL BETWEEN ONSET AND DEATH 15 M.D. UNKNOWN |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a). Prostatic Hypertrophy - ANEMIA | | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) | |
| 20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year | 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | |
| 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 20f. CITY, TOWN, OR LOCATION Green Castle, Mo. | | |
| 21. I attended the deceased from 3-22-63 to 4-2-63 and last saw him alive on 4-2-63 Death occurred at 4:14 P m on the date stated above, and to the best of my knowledge, from the causes stated. | | 22a. SIGNATURE Paul Laughlin, Jr. DO (Degree title) | |
| 22b. ADDRESS KIRKSVILLE, Mo. | | 22c. DATE SIGNED 4-16-63 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE 4-6-1963 | 23c. NAME OF CEMETERY OR CREMATORY Green Castle Cemetery | 23d. LOCATION (City, town, or county) Green Castle, Mo. |
| 24. FUNERAL DIRECTOR Glenn E. Feltman, Green City, Mo. | | 25. DATE RECD. BY LOCAL REG. 4-18-1963 | 26. REGISTRAR'S SIGNATURE Norris W. Ratliff |

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK
OR
TYPEWRITER RIBBON

Cornet named April 2, 1963

Earl Laughlin, Jr., D.O.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

Karl R. Kent

Licensed Embalmer No.

4689

P. O. Address

Green City, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.